FirstCare HEALTH PLANS

FirstCare *PPO*

Permian Basin Employer Health Plan Business Cooperative Benefit Summary - **Plan B Low (1500)**

	PREFERRED PROVIDER (In-Network Benefits)	NON-PREFERRED PROVIDER (Out-of-Network Benefits)
Deductible per Calendar Year (Does not apply toward Out-of-Pocket Maximum)	$1,500 per Insured $4,500 per Family	$5,000 per Insured $15,000 per Family
Out-of-Pocket Maximum per Calendar Year	$5,000 per Insured $12,500 per Family	$15,000 per Insured $30,000 per Family
PREAUTHORIZATION PENALTY	Failure to Preauthorize reduces benefits by 50% or $500, whichever is less	
Hospital Services		
Inpatient Room & Board charges and other Inpatient charges	70% after Deductible	50% after Deductible
Outpatient Surgery Facility	70% after Deductible	50% after Deductible
Pre-admission testing	70% after Deductible	50% after Deductible
Physician and Health Care Provider Services (including Laboratory & Radiology performed during an Office Visit)		
Office Visits to Non-Specialist Includes services of an Internist, General Physician, Family Practitioner or Pediatricians for routine care as well as diagnosis and treatment of an illness or injury.	$25 per visit	50% after Deductible
Specialist Office Visits	$60 per visit	50% after Deductible
Physician Home Visits	70% after Deductible	50% after Deductible
Physician Hospital Visits	70% after Deductible	50% after Deductible
Allergy Office Visits - including testing Non-Specialist Specialist	$25 per visit $60 per visit	50% after Deductible
Allergy Serum and Supplies	70% after Deductible	50% after Deductible
Surgery (Inpatient or Outpatient)	70% after Deductible	50% after Deductible
Laboratory and Radiology Services	70% after Deductible	50% after Deductible
Preventive Health Care Services		
Annual Physicals	$25 Copayment	50% after Deductible
Well Child Care	$25 Copayment	50% after Deductible
Immunizations for Newborns (birth through 6 years of age)	Covered in full when an immunization is administered without an office visit	
Newborn Child Hearing Screenings (birth to 30 days old)	70% Deductible waived	50% Deductible waived
Screening Mammograms	Covered in full - Deductible waived	50% after Deductible
Family Planning Services		
Counseling Services	$60 Copayment	50% after Deductible
Sterilization in an Inpatient or Outpatient Surgical Facility	70% after Deductible	50% after Deductible
Outpatient Rehabilitative Services	70% after Deductible	50% after Deductible
Spinal Manipulation Services	70% after Deductible up to $50 per visit	50% after Deductible up to $50 per visit
	Limited to 10 visits per Calendar Year	
Second Surgical Opinion	$60 Copayment	50% after Deductible
Immunosuppressive Medications, , Injectable Drugs, Medically Infused Medications and Supplies, and High Technology Drugs.	70% after Deductible	50% after Deductible
Radiation Therapy, Chemotherapy and Associated Agents **Lifetime Maximum $50,000++ This does NOT increase the Aggregate Lifetime Maximum Benefit**	++This Lifetime Maximum Benefit does not apply to the treatment of cancer if after the initial diagnosis the insured receives all cancer treatment in the Covenant Health System. If an insured receives any cancer related service outside the Covenant Health System, the $50,000 Lifetime Maximum Benefit applies.	
Pain Management Services	70% after Deductible	50% after Deductible

FirstCare PPO, a Southwest Life & Health Insurance Company is a wholly owned subsidiary of SHA,L.L.C.

	PREFERRED PROVIDER (In-Network Benefits)	NON-PREFERRED PROVIDER (Out-of-Network Benefits)
Organ Transplant Services		
Physician Office Visits	70% after Deductible	50% after Deductible
Inpatient Surgery	70% after Deductible	50% after Deductible
Chemical Dependency Services		
Office Visits	$60 Copayment	50% after Deductible
Outpatient or Inpatient Treatment	70% after Deductible	50% after Deductible
	Limited to three separate series of treatments per lifetime	
Acute / Non-Chronic Mental Health Services		
Office Visits	$60 Copayment	50% after Deductible
	Maximum of 20 visits per Calendar Year	
Inpatient Services	70% after Deductible	50% after Deductible
	Maximum of 15 days per Calendar Year	
Serious Mental Illness		
Office Visits	$60 Copayment	50% after Deductible
	Maximum of 60 visits per Calendar Year	
Inpatient Services	70% after Deductible	50% after Deductible
	Maximum of 45 days per Calendar Year	
Prosthetic / Orthotic Devices / Heart Implants (Pacemakers, Stents)	70% after Deductible	50% after Deductible
Durable Medical Equipment (DME) and Medical Supplies	70% after Deductible	50% after Deductible
	Limited to $4,000 per Calendar Year	
Limited Accidental Dental Care and Medically Related Oral Surgeries		
Office Visits	$60 Copayment	50% after Deductible
Outpatient Surgery	70% after Deductible	50% after Deductible
Inpatient Services	70% after Deductible	50% after Deductible
Home Health Care		
Home Visits	70% after Deductible	50% after Deductible
	Maximum of 60 visits per Calendar Year	
Home Infusion Therapy	70% after Deductible	50% after Deductible
Skilled Nursing Facility Services	70% after Deductible	50% after Deductible
	Maximum of 60 days per Calendar Year	
Hospice Services	100% after Deductible	50% after Deductible
	Lifetime maximum amount - $20,000	
Diabetes Services		
Physician Office Visits - Non-Specialist Physician Office Visits - Specialist	$25 per visit $60 per visit	50% after Deductible
Self-Management Education	70% after Deductible	50% after Deductible
Supplies and Equipment	70% after Deductible	50% after Deductible
Insulin and Diabetic Medications (up to a 30-day supply)		
◆ 1st Tier - Generic Drugs	$15 per prescription	Paid at 70% of the actual charges, after they are first reduced by the sum of the applicable In-Network pharmacy Copayment and any required difference in the cost between a Brand Name medication and a Generic medication.
◆ 2nd Tier - Selected List of Brand Name Drugs	$35 per prescription	
◆ 3rd Tier - Other Brand Name Drugs not on 2nd Tier	$65 per prescription	
Mail Order (up to a 90-day supply)		
◆ 1st Tier - Generic Drugs	$45 per prescription	
◆ 2nd Tier - Selected List of Brand Name Drugs	$105 per prescription	
◆ 3rd Tier - Other Brand Name Drugs not on 2nd Tier	$195 per prescription	
Emergency Care Services	70% Deductible waived	
Emergency Ambulance Services	70% Deductible waived	
All Other Covered Services	70% after Deductible	50% after Deductible

AGGREGATE LIFETIME MAXIMUM - $750,000

This chart only summarizes covered benefits.
Please refer to the Certificate of Insurance for coverage details including exclusions and limitations.